Health Insurance Access Programs and Policies in Montana and Other Frontier States

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Prepared for the Montana Department of Public Health & Human Services

FINAL REPORT
July 2006

INTRODUCTION

The Montana (MT) Department of Public Health and Human Services contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to identify and summarize public, employer-based, and individual market health insurance coverage expansion initiatives that have been implemented in four frontier states. The states considered in this report are MT, Idaho (ID), South Dakota (SD), and Utah (UT).

This report is one component of Montana's current State Planning Grant activities funded by the U.S. Health Resources and Services Administration (HRSA). The following analysis is purposefully narrow in scope by focusing on only select aspects of health coverage across the states. While we acknowledge their importance, we do not address in this report other health system factors that may affect health coverage and costs.

The report first considers the need for greater health insurance coverage in MT by presenting state-specific data on the uninsured populations within the state and compares the status of coverage in MT with the three other states. The report then reviews programs and policies implemented by MT, ID, SD, and UT to improve health insurance coverage within their states. Three categories of initiatives are considered across the four states: Medicaid/ State Children's Health Insurance Program (SCHIP) expansion programs; small employer-focused approaches; and group/non-group insurance initiatives. Following discussion about these efforts, the report concludes with a summary of program highlights from the four states.

MONTANA'S UNINSURED

The 2003 Montana Household Survey estimated that 19% of MT's population lacks health insurance coverage. Table 1 presents the uninsurance rates for various population groups in MT by age, ethnicity, income, and employment. As with other parts of the country, young adults between the ages of 19 and 25, Native Americans, low-income individuals, and unemployed residents in MT are most likely to be uninsured.

Table 1 also shows data on the demographic composition of the uninsured population in the state (younger than 65 years of age). Whereas young adults are most likely to lack insurance, Montanans aged 26-49 years make up the largest age group of uninsured nonelderly (42%), and the near elderly (50-64 year olds) comprise another 25% of the uninsured. The majority of Montanans who lack coverage are white (86%), and not surprisingly given the rural composition of the state, more uninsured live in rural rather than urban areas. While lower-income residents are at greater risk of lacking insurance, 45% of the uninsured non-elderly in MT have incomes above 200% of the Federal Poverty Level (FPL). The majority (77%) of the uninsured also are employed.

Table 1: Uninsurance Rates for Key Demographic Groups and Demographic Characteristics of the Uninsured – Montana, 2003

Demographic	Uninsurance Rate (All ages)	Proportion of Uninsured (< 65 years of age)
Age		
0-18 years	17%	18%
19-25 years	39%	15%
26-49 years	24%	42%
50-64 years	14%	25%
65+ years	<1%	--
Under 65 years	22%	--
All ages	19%	--
Total	--	100%
Ethnicity		
White and other	20%	86%
American Indian	38%	14%
Total	--	100%
Residency		
Urban	21%	43%
Rural	23%	57%
Total	--	100%
Income		
< 100% FPL	43%	12%
101-125% FPL	34%	16%
126-150% FPL	48%	10%
151-200% FPL	35%	17%
201+% FPL	13%	45%
Total	--	100%
Employment Status		
Employed	19%	51%
Self-employed	24%	26%
Unemployed	41%	14%
Disabled	12%	2%
Full-time student	27%	5%
Retired	12%	2%
Total	--	100%

Source: 2003 MT Household Survey (Seninger 2004).

Table 2 provides additional data from the 2003 Montana Household Survey on the *working* uninsured in the state. Most employed residents lacking insurance (over 80%) are engaged in permanent employment, and nearly two-thirds work for firms with fewer than 20 employees (a cut-off used in federal continuation health coverage policy, discussed further below).

The availability of employer-sponsored insurance was documented by the 2006 Employer Survey on Health Insurance Coverage in Montana, a survey of a representative sample of MT's businesses. The study found that small firms in the state are least likely to offer health insurance to their employees (see Table 3). This is especially the case for very small firms, with only 40% of firms with five and fewer workers and not many more than half of firms with six to ten employees offering insurance. Additionally, almost a third of MT employers with 11-19 employees do not provide insurance.

Table 2: Employment Characteristics of the Employed Uninsured – Montana, 2003

Characteristic	Proportion of Uninsured (< 65 years, employed)
Type of Employment	
Permanent	84%
Temporary	7%
Seasonal	9%
Total	100%
Employer Size	
1 employee	20%
2-10 employees	36%
11-19 employees	9%
20-50 employees	12%
51-100 employees	6%
101-500 employees	5%
501+ employees	12%
Total	100%

Source: 2003 MT Household Survey (Seninger 2004).

Table 3: Employer-Sponsored Health Insurance Offers, by Firm Size – Montana, 2006

Firm Size	No Insurance Offer	Offer to Employees
1-5 employees	60%	40%
6-10 employees	47%	53%
11-19 employees	31%	69%
20-100 employees	17%	83%
101+ employees	2%	98%

Source: 2006 Employer Survey on Health Insurance Coverage in Montana (Seninger 2006).

HOW MONTANA COMPARES TO IDAHO, SOUTH DAKOTA, AND UTAH IN UNINSURANCE RATES

Table 4 presents insurance coverage data from the Current Population Survey for individuals in each of the four states, by age group, poverty level, and employment characteristics.[1] Across all indicators, MT and ID do not differ significantly in their uninsurance rates. However, for many of the indicators, MT's uninsurance rates are consistently higher than both SD's and UT's. Both children and non-elderly adults, for example, are more likely to be uninsured in MT than in SD and UT. Montanans at all income levels are more likely to be uninsured compared to their income counterparts in SD, and more Montanans between 100-200% FPL are uninsured than those in the same income bracket in UT. Finally, certain groups of workers in MT also are more likely to lack insurance than those in SD and UT. Specifically, more individuals employed by private employers, self-employed workers, and employees of small businesses go uninsured in MT than they do in SD and UT.

[1] Uninsurance rates from the Current Population Survey may vary from individual state survey results. See, for example, Call et al. (under review). Current Population Survey data are used here to facilitate comparison across states.

Table 4: Uninsurance Rates by Demographic and Employer Characteristics – Montana, Idaho, South Dakota, and Utah, 2004/2005

Characteristic	Montana	Idaho	South Dakota	Utah
Age				
0-18 years	17.1%	11.7%	8.4% *	10.1% *
19-64 years	24.1%	22.2%	16.5% *	16.9% *
Under 65 years	22.1%	18.8%	13.9% *	14.4% *
All ages	19.2%	17.0%	12.1% *	13.4% *
Income (0-64 years)				
<100% FPL	39.0%	37.7%	27.5% *	35.8%
100-199% FPL	32.5%	27.7%	22.0% *	19.2% *
200%+ FPL	13.8%	12.7%	9.5% *	10.1%
Employer Type (19-64 years, employed)				
Private	25.1%	22.1%	15.3% *	17.5% *
Government	8.1%	6.0%	11.9%	8.9%
Self-Employed	29.1%	29.7%	17.4% *	18.0% *
Employer Size (19-64 years, employed)				
<10 employees	32.3%	31.1%	23.9%	22.4% *
10-24 employees	36.7%	28.2%	23.3% *	22.4% *
25-99 employees	21.1%	20.7%	16.5%	21.8%
100+ employees	11.1%	12.7%	7.9%	11.3%

Source: Pooled data from 2004/2005 Current Population Survey-Annual Social and Economic Supplement. Analyses conducted by SHADAC.

* indicates that rate is statistically different from MT's rate at a p<.05 level.

INITIATIVES IN FRONTIER STATES TO IMPROVE ACCESS TO HEALTH INSURANCE

This section reviews three categories of initiatives that MT, ID, SD, and UT have implemented to expand health insurance coverage within their states: Medicaid/SCHIP programs (see Tables 5 and 6); small employer-focused initiatives (see Table 7); and group/non-group insurance initiatives (see Table 8). We provide a summary of the programs across the four states and highlight similarities and differences. The tables (located at the end of the report) provide more detailed information about each state's programs, including target groups and eligibility, estimated and/or actual enrollment levels, and benefit packages and cost sharing (as relevant).

Information about the initiatives discussed in this report was derived from a review of secondary sources conducted by SHADAC between January and March 2006. Sources included state government websites as well as reports and data available from organizations such as the AcademyHealth State Coverage Initiatives program, Centers for Medicare and Medicaid Services (CMS), National Governors Association, The Commonwealth Fund, and Kaiser Family Foundation. Correspondence with state staff in Montana also provided additional information about the programs in this state. The reference list at the end of this report lists the specific sources used. It is important to note that state policies and programs and the status of state initiatives may have changed since these information sources were created or published.

Medicaid/SCHIP-Based Initiatives

Tables 5 and 6 outline key Medicaid and SCHIP-related initiatives that MT, ID, SD, and UT have implemented to expand health insurance coverage within their states. We focus on these states' SCHIP programs as well as their CMS Medicaid and SCHIP Section 1115 Demonstration Waivers. State flexibility in design of these programs has led to variation in initiatives across states.

SCHIP Programs

With the passage of the Balanced Budget Act of 1997, states began to implement SCHIP programs in 1998. States had the option of implementing their programs using one of three approaches: establishing a program separate from their Medicaid program, expanding their Medicaid program for children, or a combination of both approaches. None of the four states highlighted in this report originally structured their SCHIP initiative as a combination program. Both MT and UT initially established and maintained a separate SCHIP program. In contrast, SD began their SCHIP program through a Medicaid eligibility expansion ("Medicaid-CHIP") and subsequently added a separate SCHIP program ("CHIP-Non Medicaid") two years later. Likewise, ID started with a Medicaid eligibility expansion program (now called CHIP-A) but in 2004 introduced a separate SCHIP program (CHIP-B) as well. Therefore, all of the four states have a separate SCHIP program in place; two of the four also have expanded Medicaid eligibility for children (see Table 5).

Eligibility. Taking into consideration both Medicaid eligibility expansions and separate SCHIP programs, the SCHIP income eligibility levels currently in place across the four states range from 150% to 200% FPL, with MT the least generous (150% FPL), SD and UT the most inclusive (200% FPL), and ID in between (185% FPL). All four states focus on children younger than 19 years and have not expanded eligibility to 20- or 21-year olds. MT, ID and UT all have implemented enrollment caps for their separate SCHIP programs. ID, however, recently eliminated their cap. MT, through increased funding from revenue generated by a tobacco tax in 2005, terminated their cap as well and has since expanded enrollment. (This is in addition to a recent change in Medicaid eligibility that will transfer some children from SCHIP to Medicaid. The Medicaid adjustment involves the removal of the asset test for children under poverty who have assets of <$15,000.)

Benefit Package. SCHIP benefits vary across the states depending on the program type implemented. The two states with Medicaid expansions in place (ID and SD) extend their states' standard Medicaid benefits to eligible children. SD also provides full Medicaid benefits to children enrolled in their separate SCHIP program; in contrast, ID offers a less extensive package under their separate SCHIP program. For MT and UT, the two states with separate SCHIP programs only, the benefits are benchmarked against their state employee health plan. Assuming a beneficiary meets certain conditions, twelve months of eligibility are guaranteed in MT, ID, and UT.

Cost Sharing. UT is the only state that requires *all* SCHIP beneficiaries to contribute to some of the costs of the program. In MT, ID and SD, at least some of the beneficiaries (e.g., those with family incomes at or below 100% FPL) have access to completely subsidized benefits. Overall,

SD is the most generous in this regard: under both their Medicaid expansion program and separate SCHIP program, there are no co-payments, premiums or coinsurance costs for beneficiaries, and the benefits under each program (as discussed above) are identical. ID also incorporates no cost sharing under their Medicaid expansion program, but the state does require a $15/month premium for beneficiaries enrolled in their separate SCHIP program (which also has a more limited benefits package).

Both MT and UT have applied a two-tiered cost sharing structure based on family income to their separate SCHIP program. While all children within each program receive the same benefits package, beneficiaries with higher family incomes are responsible for more cost sharing. Under MT's system, children whose family income is at or below 100% FPL are not required to contribute to program costs, whereas children with higher incomes have co-payments up to a maximum amount of $215 per family per year. In UT, on the other hand, all beneficiaries are required to contribute some out-of-pocket payments, but the cost sharing is less expensive for children whose family income falls below 151% FPL. In both UT and MT, 100% of well-baby/well-child visit costs, regardless of family income, are covered without cost-sharing by the separate SCHIP program. Also, no beneficiary co-payments are required for dental services in MT. American Indian children are exempt from SCHIP cost sharing in all states (Guyer and Mann, 2006).

Section 1115 Medicaid/SCHIP Waivers

Section 1115 waivers, including Health Insurance Flexibility and Accountability (HIFA) waivers, are mechanisms for states to pilot new policy approaches for improving health insurance coverage in their states and to maximize state resources and federal match dollars in the process. The waivers can be used to expand Medicaid/SCHIP eligibility and/or benefits. They are approved for five years, but renewals may be requested. Of the four states addressed in this report, all but SD have applied for and implemented Section 1115 waivers in recent years (see Table 6).

Target Groups and Eligibility. Working adults, parents, and adults without children have been a primary focus of recent waiver initiatives across the country (State Coverage Initiatives, 2006b). UT's waiver focuses exclusively on adults. MT and ID have implemented or are implementing Section 1115 waivers to address both adults and children. The inclusion criteria for target groups vary from state to state, and categories are not necessarily mutually exclusive.

> *Working adults:* The waiver programs in all three of the states target working adults. Under ID's HIFA Demonstration Waiver, employees of small businesses with incomes up through 185% FPL are eligible for the Access to Health Insurance program. Under UT's Section 1115 Waiver, a program called Covered at Work directs assistance to working adults with incomes up to 150%. And the Medicaid Redesign Waiver in MT (application pending) will extend coverage to a particular subset of employed adults—working parents of Medicaid-eligible children and with incomes up through 200% FPL. Of the three waivers, UT's will reach the largest number of working adults (cap of 6,000 in UT, cap of 1,000 in ID, and an estimate of 600 in MT).

Parents and childless adults: Waivers in both MT and UT provide benefits to other uninsured adults. MT's Basic Medicaid for Able-Bodied Adults waiver targets uninsured parents and caretakers of dependent children, aged 21-64 years and who are neither pregnant nor disabled. UT's Primary Care Network extends coverage to uninsured 19-64 year olds (parents or childless adults) with incomes at or below 150% FPL. Both MT's and UT's programs provide scaled-down benefits (see more below on benefits) to a fairly large number of uninsured adults (well over 15,000 are eligible or are enrolled in each program). Both of these programs also have generated some controversy: In order for the programs to be "budget neutral," a requirement of the Section 1115 Waiver program, both states reduced optional benefits and increased cost-sharing for some mandatory Medicaid beneficiaries.

Young adults: The MT and UT waivers direct coverage specifically to young adults. Both programs under UT's waiver (the Primary Care Network and Covered at Work programs) include young adults 19 to 25 years of age. MT's pending HIFA waiver explicitly anticipates providing coverage to about 300 former seriously emotionally disturbed (SED) youth aged 18 to 20 years who have incomes at or below 150% FPL.

Children: The Section 1115 waivers in two of the states (MT and ID) also target particular subgroups of children. MT's pending waiver will expand coverage to additional uninsured children up through 150% FPL (the same eligibility level as their SCHIP). In ID, the Idaho Access Card program targets S*CHIP enrollees*, and the Access to Health Insurance program under the same waiver offers coverage to dependents of small business employees with incomes at or below 185% FPL**.**

Benefits and Cost Sharing. The benefits offered to adults by the waiver programs in MT, ID, and UT are either a reduced benefits package or premium assistance. For children, the waivers in MT and ID offer SCHIP-equivalent coverage or premium assistance.

MT's Basic Medicaid for Able-Bodied Adults is a restricted Medicaid benefits package that is intended to resemble standard employer-based coverage and is more comprehensive than those offered under UT's Primary Care Network. UT's benefit package focuses on primary and preventive services and does not include inpatient hospital care. Cost sharing is arranged differently between the two programs. MT has lower co-payments/coinsurance and no enrollment fee, and UT requires a maximum of $1,000 in cost sharing from its beneficiaries.

Premium assistance for adult workers is provided under MT's Medicaid Redesign Waiver, ID's Access to Health Insurance program, and UT's Covered at Work program. The subsidies for individuals range from $50 per month in UT to $167 per month in MT. Family subsidies range from $100 in UT's program to $500 per family in ID. As an alternative to premium assistance, enrollees in MT's program will have the option of electing Medicaid fee-for-service benefits. Some beneficiary costs are expected or possible under all of these worker premium assistance programs.

The premium assistance benefit for *children* under ID's Access Card is a unique demonstration program that provides an alternative to direct health coverage (under the state plan) to SCHIP

enrollees. Beneficiaries who elect the Access Card option receive up to $100/month, or $300/month for families with three or more children, in premium assistance to be used toward a private or employer-sponsored insurance plan chosen by the family. The benefits provided and actual cost sharing under the plan depend on the selected plan. Parents of beneficiaries are responsible for any remaining balance of premium costs, co-payments and deductibles. Regardless of plan selection, all child immunizations are covered at no cost to the family.

Small-Employer Initiatives

MT, ID, SD, and UT have implemented several small employer-focused access initiatives including state continuation coverage programs, premium assistance, tax credits and reinsurance (see Table 7). Recent legislation in MT stands out as an effort to stimulate and support the state's small business health insurance offerings.

State Continuation Coverage/Consolidated Omnibus Budget Reconciliation Act (COBRA) Expansions

Passed in 1986, COBRA is a federal initiative that provides temporary continuation of group health coverage for eligible employees (and their dependents) under specific conditions such as termination of employment or reduction in hours worked. Employees who elect COBRA coverage have to pay the full cost of the premium. The law is only applicable to businesses with 20 and more employees. However, many states have expanded COBRA and made similar provisions to continue group health coverage for employees of small businesses (2-19 employees). This is known as state continuation coverage, or mini-COBRA. (Continuation rights apply to businesses/health plans that are fully insured, because they fall under the purview of state regulations.) Of the four states reviewed in this report, only two — SD and UT — have such provisions for employees of small businesses. As shown in Table 7, SD's temporary group health coverage is more generous, extending to 18 months or in some cases, 36 months. UT, on the other hand, allows for continuation coverage for only six months following termination of employment.

Premium Subsidies

To boost offer and take-up rates of employer-sponsored health insurance, many states have established premium subsidies. Recently, both MT and ID made legislative provisions to subsidize premium costs in an effort to make health insurance more affordable for small businesses and their employees. In MT, small businesses (2-5 employees) that do not currently provide insurance coverage to workers are eligible for the subsidies. Employees also must meet certain income eligibility requirements. Subsidies are available for both employers and employees (and their dependents): premium assistance is applied to the employees' share and premium incentives are applied to the employers' share of the premium. As a requirement of the premium subsidy program, participating employers must begin to offer health insurance through the Small Business Health Insurance Pool (created as part of the initiative) or another qualified plan. MT started this program in 2005 and intends to secure Medicaid matching funds for these subsidies for families with incomes at or below 200% FPL through its 1115 waiver application in progress.

In ID, up to 1,000 employees of small businesses (2-50 employees) are receiving premium subsidies through the state's 1115 waiver. The Access to Health Insurance program (under the Idaho Access Card program) offers premium assistance in the amount of $100 per month, or $500 per month for a family. Three small business employee groups (and their dependents) are targeted: parents of Medicaid/SCHIP children, pregnant women, and childless adults, all with incomes up through 185% FPL. As part of the program, employers must pay at least 50% of their employees' premium. This initiative, which started up in 2004, is funded through a combination of Medicaid and SCHIP funds.

Tax Credits

To further encourage and support employer-sponsored health insurance, MT offers refundable tax credits to eligible small businesses (2-5 employees) that currently offer insurance to their employees. Effective in 2006, tax credits are available for employers to continue covering employees. Funds for these tax credits are limited (enrollment is on a first-come, first-served basis) and are generated through tobacco product taxes. Taking into consideration the four states being reviewed in this report, tax credits incentives are unique to MT.

Reinsurance

In addition to premium subsidies and tax credits, reinsurance is another mechanism states have used to improve premium affordability. Reinsurance is basically insurance for the insurer. An insurer transfers some of its risk to a reinsurer, thus requiring fewer reserves and surpluses to be built into the premiums and therefore lower premiums. Among the states considered in the report, ID is the only state that uses reinsurance in both the small group and the non-group (individual) market (reinsurance in the non-group market is discussed in the next section). For ID's small businesses that participate in a reinsured plan, the insurer is responsible for the first $13,000 in claims as well as 10% percent of the next $13,000 (basic plan), $88,000 (standard plan), and $130,000 (catastrophic plan). Claims in excess of these amounts are covered by the reinsurance pool to the maximum amount set for each plan (see Table 7). The reinsurance pool in ID has been in place since 1994 and is funded by insurer premiums and assessments that may be levied on all insurers statewide.

Limited Benefits

Historically, states have mandated insurers to offer certain benefits/services as part of a comprehensive coverage option to enrollees. These mandated benefits vary from state to state, the most common ones being mammography and diabetes supplies. However, recent state regulations in favor of limited or "mandate-light" benefit plans – designed to reduce premium costs and present a new coverage alternative to the uninsured – suggest a departure from this concept.

Among the four states discussed in this report, UT is the only one with the necessary legislation in place to give insurers permission to provide small employers with a minimum health benefits package. In UT, limited benefit plans must at least cover primary and preventive services similar to those under their Primary Care Network program described earlier (including physician services, emergency room visits, prescription drugs, dental and vision care). In fact, the timing and content of UT's limited-benefit legislation was coordinated with the waiver that

established the Primary Care Network. Interestingly, no insurers have come forward to market this option to date.

Group and Non-Group Insurance Initiatives

This section summarizes the state insurance initiatives that target the group and non-group (individual) markets (see Table 8). The initiatives reviewed include high risk pools, limited-benefit plans, and reforms in the state regulations to truly enhance coverage. MT's high risk pool offers moderate coverage to its enrollees and has also implemented a unique premium assistance pilot program complementary to its high risk pool. It also offers limited-benefit plans in the non-group market.

High Risk Pools

High risk pools are created to offer comprehensive health insurance benefits to individuals who are medically uninsurable. These individuals may have been denied private coverage, can only avail restricted coverage, or are assessed higher premiums due to pre-existing medical conditions. All four states have high risk pools and have implemented strategies complementary to their respective pools (such as premium assistance or reinsurance) to enhance coverage.

The MT Comprehensive Health Association (MCHA) makes health insurance provisions for Montanans who are ineligible for coverage through public programs, who have been rejected by at least two insurers in the past six months, and who were denied private insurance due to medical conditions. The MCHA is their "last resort" for coverage and is sometimes referred to as MT's high-risk pool. This function is served in ID's Individual High Risk Reinsurance Pool, the South Dakota Risk Pool, and in UT's Comprehensive Health Insurance Pool (HIPUtah). The MCHA is the oldest pool, established in 1987, and SD's pool, established in 2003, is the most recent pool. In terms of pool size, MCHA (1,827 enrollees) has more enrollees than ID's and SD's pool, but is nearly half of HIPUtah (3,085 enrollees).

Eligibility. All of these high risk pools offer coverage to uninsured residents. Generally, individuals have to be considered uninsurable and must have been rejected by insurers. However, states vary in their eligibility specifications. For example, MT requires rejections from at least two insurers within a six-month time frame, while SD requires that individuals had at least 12 months of previous continued coverage. SD and UT also require that individuals apply to the high risk pool within a certain window of time following coverage loss or denial (63 days and 30 days, respectively).

Benefit Design. All four high risk pools offer in-patient and out-patient coverage, X-ray or diagnostic services, and prescription drug coverage. In terms of other available services, MT's pool is comparable to those in the other states. Preventive care also is available in MT, ID and UT. Disease management is covered in MT and SD and may be offered by some of the participating insurers in ID. Dental coverage is not included in any of the state pools; vision is covered only in UT's pool. The lifetime maximum benefit across all programs is $1,000,000. In ID, however, the maximum benefit can be as low as $500,000 for some of their individual plans.

Premium Caps. Although high risk pool premiums are high, states cap premiums relative to average standard risks to ensure premium affordability for enrollees. Under the MCHA, individual premiums are not to exceed 200% of the average premium rates charged by the top five insurers in the individual market. This is the highest premium ceiling compared to the other three states, where premium rates are set at 150% (in ID, SD and UT) of the standard risk rates in the individual markets.

Cost Sharing. In terms of cost-sharing, MT's MCHA offers plans with an annual deductible of either $1,000 or $5,000, both with 80/20 coinsurance. Annual deductibles in ID, SD and UT vary—the lowest being $500 for certain plans in ID and UT and the highest being $10,000 in SD. Depending on the plan, the other states' coinsurance rates range from as low as MT's 80/20 (in UT and for certain plans in ID) to as high as 50/50 (the basic plan in ID). The coinsurance level for SD's high risk pool falls in between at 75/25.

Pre-Existing Conditions and Look-Back Period. While high risk pools are designed to serve individuals with chronic medical conditions, regulations on pre-existing conditions and look-back periods are imposed to limit adverse selection in high-risk pools to the extent possible. Of the four states, MT and ID require the longest waiting period, at 12 months for any pre-existing condition. MT has the longest look-back time of these states, at three years for any diagnosis/treatment for medical conditions prior to the application. UT, on the other hand, has a much shorter waiting period for those with pre-existing conditions (six months), and SD has none. MT, ID, and UT do waive their waiting list restrictions under certain circumstances.

Premium Assistance for High Risk Pool

In 2002, the MT State Legislature initiated an innovative premium assistance pilot program for its high risk pool (MCHA) enrollees with incomes at or below 150% FPL. Individuals enrolled under this initiative receive subsidies in the amount of 45% of their premium costs. Offering premium assistance to high risk enrollees is a unique initiative in this frontier state. With support from federal grants, in 2005, the MT State Legislature allotted $570,000 to support the premium assistance program. MT also is considering an 1115 waiver to secure Medicaid funding for a portion of the premium assistance for eligible low-income individuals. As of June 2005, 200 people were enrolled in the program.

Reinsurance for High Risk Pool

ID's non-group (individual) high-risk pool is unique compared to its equivalents in MT, SD and UT due to its reinsurance component, which transfers some of the risk of its high-cost enrollees to a reinsurance pool. Insurers are responsible for the first $5,000 in individual claims and the reinsurer is responsible for 10% of the next $25,000. All claims exceeding $25,000 are covered by the reinsurance pool, up to the lifetime maximums of the guaranteed issue products. This reinsurance pool is funded through reinsurance premiums contributed by participating insurers, a portion of the state's premium tax revenue and assessments on insurers, if required.

Limited-Benefit Plans

Since the early 2000s, both MT and UT Legislatures have approved insurers to offer limited benefit plans. At present MT offers this only in its non-group (individual) market, whereas UT offers these plans to both individuals and small employers (discussed earlier). In MT thus far,

only one insurer offers a limited benefits product and is required to disclose limited/uncovered services to enrollees. Limited services pertain to newborn coverage, severe mental illness and emergency services. Also, in-patient services are not covered. The MT demonstration project is capped at 1,000 enrollees, but so far only 53 individuals have enrolled.

In UT, the limited benefit plan covers primary and preventive services similar to their Primary Care Network program (as discussed earlier). UT's limited benefits plan is similar to the plan in MT in that it does not cover inpatient care. However, the package offered in UT is more comprehensive than that offered in MT. As mentioned already, no insurers have come forward to market this option.

Enhancing Coverage through Insurance Market Regulations

To successfully implement health coverage enhancing initiatives, the insurance market regulations in each state also need to be considered. Many states have adopted insurance reforms in the small group or non-group (individual) market concerning guaranteed issue and renewal, rating practices, exclusions for pre-existing conditions, and minimum loss ratios. ID law, as a result of several forward-looking reforms in the health insurance market, mandates guaranteed issue, portability and renewability of all health benefit plans, both group and non-group. ID law requires that a carrier offering non-group health insurance must also "actively offer" all plans under the individual high risk reinsurance pool to potential enrollees.

SUMMARY OF INITIATIVES

MT, ID, SD, and UT have implemented a variety of initiatives to expand access to health insurance coverage for their residents. Based on this review of Medicaid/SCHIP, small employer-focused, and group/non-group insurance initiatives, several programmatic approaches standout among these states.

First, the following program highlights come from MT:

- *Section 1115 Able-Bodied Waiver:* With over 17,000 uninsured adults eligible, this program provides restricted benefits to a large number of people. In order to extend fewer benefits more broadly, the program reduces optional benefits.
- *HIFA Waiver:* MT's pending HIFA demonstration waiver application attempts to address gaps in coverage across public, employer-based, and individual health insurance markets.
- *Small business legislation*: MT is the only state among the four to combine premium assistance with tax credits to recognize and incentivize small businesses that are already providing health insurance to their employees. Also of note is MT's Small Business Health Insurance Pool, which the state is incorporating as part of their premium assistance/incentives program.
- *Premium assistance for individual high risk pool*: Of the four states, MT is the only state that has attempted a program to make their pool more accessible for certain low-income individuals.

Program highlights from the other frontier states – ID, SD, and UT – include the following:

- *Higher SCHIP eligibility levels:* Compared to MT's 150% FPL cap, ID, SD, and UT have eligibility levels starting at 185% FPL.
- *Premium assistance option for SCHIP enrollees*: ID's HIFA demonstration waiver explores an alternative to public coverage benefits for SCHIP enrollees by offering premium assistance to be used toward obtaining individual-market or employer-based insurance.
- *Mini-COBRA programs*: SD and UT have expanded federal COBRA coverage to employees of small businesses.
- *Limited benefits for small employers:* UT has authorized insurers the option to provide small employers with a restricted health benefits package.
- *Reinsurance:* ID is the only state reviewed in this report that uses reinsurance in the small-group market and for its high risk pool.

State health coverage efforts reflect the need for reform, the political climate, and the capacity to develop and pursue reform initiatives. MT, ID, SD and UT have used a combination of public sector approaches, private sector strategies, and insurance reforms. Section 1115 waivers and state legislation have played a significant role in shaping the landscape and accessibility of public, employer-based, and group/non-group market health insurance programs in these states.

Table 5: SCHIP Programs in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
MT				
	Separate CHIP Program[1] Initiated in 1998 ("MT's Children Health Insurance Plan") State Plan amended in 1999, 2002; new amendment submitted in 2005 Expanded funding and enrollment in 2005 (increased state funding through a tobacco tax)[2]	Family income limit initially set and has remained at ≤150% FPL for children < 19 years One-month period of uninsurance required (some exceptions apply)[3]	No enrollment cap effective July 2005[3] 12,594 children as of 04/2006[4]	<u>Benefits:</u> Benchmarked on state employee health plan[4]; includes • Inpatient/outpatient hospital • ER • Physician • Surgical • Lab and x-ray • Well-child/well-baby visits and immunizations • Prescription drugs • Mental health and substance abuse treatment • Hearing and vision exams • Dental ($350 maximum payment per benefit year) <u>Cost Sharing:</u> • No co-pays for families with incomes ≤100% FPL • Co-pays ($3-$25) for >100% FPL; annual family co-pay max is $215 per benefit year • No annual enrollment fee • No co-pays for well-baby/child care, immunizations and dental services[3] <u>Continuous Eligibility:</u> Eligibility is determined every 12 months. An enrollee remains eligible unless child moves from state, moves in state and CHIP is unable to locate family, is eligible for Medicaid, is eligible for state employee benefit plan, found to have other creditable health insurance, turns 19 in age, or becomes an inmate of public institution.[5]

Table 5: SCHIP Programs in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
ID				
	Medicaid Eligibility Expansion[6] Initiated in 1998 ("CHIP-A") Amended in 1998, 2000, 2002	Family income limit initially set at ≤160% FPL for children < 19; then lowered to 150% FPL via amendment	Monthly enrollment of 12,884 children as of 12/2004 (this includes both CHIP-A and B)[7]	Benefits: Standard Medicaid benefits; includes • Inpatient/outpatient hospital • Inpatient psychiatric • Physician and other practitioners • Clinical • Dental • Home health • Lab and X-ray • Prescription drugs • EPSDT Cost Sharing: No premiums and co-pays Continuous Eligibility: 12-month continuous eligibility period[8]
	Separate CHIP Program Initiated in 2004 ("CHIP-B", via amendment) Amended in 2004, 2005	Children < 19 with family incomes at 151%-185% FPL Six-month period of uninsurance required	Enrollment cap was in place but now eliminated Monthly enrollment of 12,884 children as of 12/2004 (this includes both CHIP-A and B)[7]	Benefits: Not as comprehensive as CHIP-A[9]; includes • Inpatient/outpatient care • Well-baby/well-child services and immunizations • ER • Prescription drugs • Diagnostic • Vision • Inpatient and outpatient mental health services • Emergency dental only • Therapy (by hospital only) Cost Sharing: • $15/month premiums • No co-pays

Table 5: SCHIP Programs in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
SD				
	Medicaid Eligibility Expansion[10] Initiated in 1998 (Medicaid-CHIP, or "M-CHIP") Amended in 1999, 2000, 2002	Family income limit initially set at ≤ 133% FPL for children < 19; then increased to 140% FPL via amendment	Monthly enrollment of 10,466 as of 12/2004[7]	Benefits: Same as standard Medicaid benefits with most thru managed care system; includes • Inpatient/outpatient hospital • Physician • Prescription drugs • Mental health • EPSDT • ER (fee for service, FFS) • Dental (FFS) • Vision (FFS) • Chiropractic (FFS) • Nursing facility (FFS) Cost Sharing: No cost sharing
	Separate CHIP Program Initiated in 2000 (CHIP-Non Medicaid, or "CHIP-NM") Amended in 2002	Children < 19 with family incomes at 140%-200% FPL Three-month period without group coverage required in most cases		Benefits: Same as M-CHIP Cost Sharing: No cost sharing

Table 5: SCHIP Programs in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
UT				
	Separate CHIP Program[11] Initiated in 1998 ("UT CHIP") Amended in 2000, 2003, 2005	Children < 19 with family income ≤ 200% FPL Plan A = ≤150% FPL Plan B = 151-200% FPL Child is deemed ineligible if voluntarily terminated certain types of coverage in the three months prior	Enrollment cap of 24,000 established in 2002, revised to 28,000 in 2002, and increased to 40,000 in 2005. 38,693 enrollees during FY 2004	Benefits: Benchmarked to the Utah State Employees Health Plan; services provided by managed care organizations; includes: • Inpatient/outpatient hospital • ER • Outpatient office • Prescription drugs • Lab and X-ray • Dental (limited)[12] • Mental health inpatient/outpatient (limited)[12] • Hearing and vision (limited)[12] • Therapy[12] Cost Sharing: • $13/quarter (Plan A) and $25/quarter (Plan B) premiums • Co-pays are $1-3 for Plan A; $5-35 for Plan B; no co-pay for well-child exams and immunizations[12] • Coinsurance ranges from 10-50% of allowed costs for certain services under Plan B Continuous Eligibility: 12-month continuous eligibility period[13]

[1] All information for MT's SCHIP program comes from Centers for Medicare and Medicaid Services (CMS) (2002a), unless otherwise indicated.
[2] MT State Legislature (2005c); MT Department of Public Health and Human Services (2006c).
[3] MT Department of Public Health and Human Services (2006c).
[4] MT Department of Public Health and Human Services (2006d).
[5] National Governors Association (2003b); MT Department of Public Health and Human Services (2006c).
[6] All information for ID's SCHIP program comes from CMS (2005b), unless otherwise indicated.
[7] The Kaiser Family Foundation (2004).
[8] National Governors Association (2003a).
[9] ID Department of Health and Welfare (2006b).
[10] All information for SD's SCHIP program comes from CMS (2002b).
[11] All information for UT's SCHIP program comes from CMS (2005e), unless otherwise indicated.
[12] UT Department of Health (2004).
[13] National Governors Association (2003d).

Table 6: Medicaid/SCHIP Waivers in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
MT				
	HIFA Demonstration Waiver[1] Medicaid Redesign State legislation enabling waiver in 2005 Waiver application and CMS approval pending	Uninsured Mental Health Services Plan (MHSP) participants ≤150% FPL Uninsured children ≤150% FPL Former seriously emotionally disturbed (SED) youth ages 18-20, ≤150% FPL Working parents ≤200% FPL with Medicaid-eligible children[2]	Estimated: • 1,500 MHSP clients[2] • 1,500 children[2] • 300 former SED youth • 600 working parents	Benefits: For MHSP and working parents (up to $2,000 in total value): • Premium assistance for employer-sponsored or private market insurance or Medicaid fee-for-service benefits For uninsured children and SED youth: • SCHIP-equivalent package Cost Sharing: • For MHSP: Part of premium • For SED youth: same as SCHIP program • For uninsured working adults: premium assistance paid by Medicaid; co-pay the responsibility of recipient depending on chosen private health plan[3]
	Section 1115 Waiver[4] Montana Basic Medicaid for Able-Bodied Adults Initiated in 2004 Amended in 2004	Parents and caretakers of dependent children who are aged 21-64 years and neither pregnant nor disabled	17,137 eligible as of 1/2004	Benefits: Limited Medicaid benefits similar to typical employer insurance coverage. Stricter limits or exclusions pertain to: • Dental • Vision and hearing • Personal services • Durable medical equipment Cost Sharing: Cost sharing is equivalent to State Plan amounts. • $1-$5 co-pays • $100 coinsurance on hospital stays • $25 monthly prescription max • No enrollment fee • No cost sharing for tribal members receiving services at Indian Health Service

Table 6: Medicaid/SCHIP Waivers in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
ID				
	HIFA Demonstration Waiver[5] Idaho Access Card Initiated in 2004	Enrollees of CHIP-A and CHIP-B (i.e., children with family incomes ≤150% FPL (CHIP-A) or 151-185% FPL (CHIP-B)) As part of the Access to Health Insurance Program, small businesses with 2-50 full-time employees (and dependents) with incomes ≤185% FPL. Employers must not currently offer insurance and must be willing to pay 50% of the employees' premiums.[6]	Enrollment in demonstration to be capped; first-come, first-served basis Access Card enrollment expected to be ~ 1,400 children (25% of CHIP-B and <1% of CHIP-A enrollees) Small business employee enrollment capped at 1,000.[6]	Benefits: An alternative for SCHIP enrollees; instead of direct coverage under state plan, Access Card provides premium assistance to be used toward private or employer-sponsored insurance plan chosen by family. Benefit package (which should be comprehensive, including inpatient services and physician visits) will be defined by selected plan. Children immunizations covered in all cases and at no cost. • Up to $100/month, or $300/month for those with 3+ children, in premium assistance[6] For small business employees: • Premium assistance up to $100/month per person with maximum assistance of $300/month per family. Cost Sharing: To depend on selected plan. Beneficiaries responsible for balance of premium payments, co-pays and deductibles.[6]
UT				
	Section 1115 Waiver Primary Care Network (PCN)[7] Initiated in 2002 Amended in 2002, 2003, 2004, 2005	Uninsured 19-64 year olds (parents and childless adults) with incomes ≤150% FPL (Workers' premium share must exceed 15% of household's income)	Estimated and capped at 25,000 (16,000 parents; 9,000 other adults) As of 2/2005, ~19,000 enrollees[8]	Benefits: Restricted benefits including primary and preventive care services: • Physician • Lab, X-ray, durable medical equipment • ER • Prescription drugs • Dental • Vision Inpatient hospital and long term care are not covered. Cost Sharing: • Annual enrollment fee ($15-$50 depending on income level) • $5-$30 co-pays • 5%-10% of allowed costs for certain services • $1,000 maximum in cost sharing

Table 6: Medicaid/SCHIP Waivers in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
	Covered At Work (CAW)[9] (via waiver amendment) Initiated in 2002	Workers (parents and childless adults aged 19-64 years) with incomes ≤150% FPL (i.e., those who are PCN eligible but have access to coverage at work) (Workers' premium share must exceed 5% of monthly income)	Capped at 6,000 (3,900 parents; 2,100 other adults) Counts toward PCN cap of 25,000 71 signed up as of 2/2005[8]	Benefits: Premium assistance in the form of subsidies for employer coverage. Benefits therefore depend on program. • $50/month for individual or $100/month for family[8] Cost Sharing: • No annual enrollment fee • Co-pays determined by plan • Premium costs above CAW benefit

[1] All information for MT's Medicaid Redesign Waiver comes from Families USA (2006), unless otherwise indicated.

[2] MT Department of Public Health and Human Services (2006a).

[3] MT Department of Public Health and Human Services (2006b).

[4] All information for MT's Basic Medicaid Waiver comes from Centers for Medicare and Medicaid Services (CMS) (2005c). Note: MT is amending its existing 1115 Basic Medicaid Waiver to include new HIFA waiver concepts that will provide health care coverage for more than 5,000 uninsured Montanans, upon approval from the CMS (MT Department of Public Health and Human Services, 2006a).

[5] All information for ID's Access Card program comes from CMS (2005a), unless otherwise indicated.

[6] ID Department of Health and Welfare (2006a).

[7] All information for UT's Primary Care Network comes from CMS (2005d), unless otherwise indicated.

[8] Families USA (2005).

[9] All information for UT's Covered at Work program comes from CMS (2005d), unless otherwise indicated.

Table 7: Small Employer Initiatives in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
MT				
	Small Business Health Care Affordability Act[1] 2005	Small businesses (2-5 full-time employees) that currently do not offer insurance Employees of small businesses (2-5 full-time employees) that currently do not offer insurance Small businesses (2-5 full-time employees) that currently offer insurance	6,200 employees estimated to be eligible[2] First-come, first-served basis All slots currently filled	Benefits: For businesses not offering insurance: • The Small Business Health Insurance Pool is created[2] • Monthly premium incentive (applied to employer) and monthly premium assistance (applied to employee): incentive will average $75 per employee per month; assistance will be 20%-90% of premium For businesses offering insurance: • Refundable tax credits in the amount of $100 per employee per month
ID				
	Idaho Small Employer Reinsurance Program[3] 1994	Small businesses (2-50 full-time employees)[4]	As of 4/2004, eligible employees and dependents reinsured in 44 small-group plans.	• Insurer responsible for the first $13,000 in claims and 10% of the next $12,000 (under basic plan), $87,000 (under standard plan), $130,000 (under the catastrophic plan) • For claims exceeding these amounts, the reinsurance pool pays up to $25,000 (for basic plan), $100,000 (for standard plan), $200,000 (for catastrophic plans)[5]
	Access to Health Insurance[6] (Under the Idaho Access Card 1115 Waiver) 2005	Employees of small businesses (2-50 full-time employees) that do not currently offer insurance Employee groups (and dependents) covered include[7]: • Parents of Medicaid/SCHIP children with incomes ≤185% FPL • Pregnant women with incomes ≤185% FPL • Childless adults ≤185% FPL Employers must be willing to pay 50% of the employees' premiums	Capped at 1,000 adults	Benefits: • Premium assistance up to $100/month per person with maximum assistance of $300/month per family Cost Sharing: Dependent on the selected plan. Beneficiaries responsible for balance of premium payments, co-pays, and deductibles

Table 7: Small Employer Initiatives in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
SD				
	State Continuation Coverage[8] (COBRA expansion program)	Employees of small businesses (2-19 employees) and their dependents who have had employer-based coverage for at least six months		Temporarily continues employer-based group coverage at comparatively higher premiums for 18 months (or 36 months under in some cases)
UT				
	State Continuation Coverage[9] (COBRA expansion program)	Employees of small businesses (2-19 employees) and their dependents who have had previous employer-based coverage		Temporarily continues employer-based group coverage at comparatively higher premiums for six months
	Small Employer Limited-Benefits Plan[10] 2002	Uninsured small employers	As of 7/2004, no carriers had filed	Benefits: Primary and preventive services similar to those under Utah's Primary Care Network (1115 Waiver, see Table 5) Inpatient care and long-term services are not covered

[1] All information for MT's Small Business Health Care Affordability Act comes from MT State Auditor's Office (2006), unless otherwise indicated.
[2] MT State Legislature (2005d).
[3] All information for ID's Small Employer Reinsurance Program comes from Chollet (2004), unless otherwise indicated.
[4] ID State Legislature (2005).
[5] State Coverage Initiatives (2005a).
[6] All information for ID's Access to Health Insurance program comes from ID Department of Health and Welfare (2006a), unless otherwise indicated.
[7] ID Department of Health and Welfare (2004).
[8] All information for SD's state continuation coverage comes from Pollitz, Lewis et al. (2004).
[9] All information for UT's state continuation coverage comes from Pollitz, Lucia et al. (2004).
[10] All information for UT's Small Employer Limited Benefits Plan comes from Friedenzohn (2004).

Table 8: Group and Non-Group Insurance Initiatives in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
MT				
	Montana Comprehensive Health Association (MCHA)[1] "High risk pool equivalent" 1987	Residents rejected for disability/ health insurance by at least two insurers in the last six months or have premiums >150% higher than the average rate for MCHA	1,827 enrollees as of 6/2005	Benefits: • In-patient/out-patient hospital • X-ray • Prescription drug coverage • Preventive care • Disease management added in 1999 No vision care or dental benefits. Coverage not included for pre-existing conditions during first 12 months of enrollment. Lifetime max of $1,000,000. Cost Sharing: • Premium capped at 200% of standard risk rate • $1,000 annual deductible • 80/20 coinsurance • $5,000 annual maximum deductible/co-pay expense
	MCHA Premium Assistance Pilot Project[2] 2002	MCHA-qualified individuals with family incomes ≤150% FPL[3]	200 individuals as of 6/2005[3]	Benefits: Similar to MCHA plan benefits and services Cost Sharing: Similar to MCHA plan; in addition, a premium subsidy of 45%
	Individual Limited-Benefits Plan[4] 2003	Individuals who have been uninsured for > 90 days	Enrollment cap of 1,000. As of 2004, 53 enrollees	Benefits: • Unlimited office-based care • Lab and X-ray services • Generic prescription medicines • Some mental health • Outpatient therapies • Coverage for newborns (limited) • ER (limited) • Severe mental illness (limited) Inpatient services not covered. Carriers required to disclose limited/uncovered services.[5] No restrictions for pre-existing conditions. Cost Sharing: Co-pays and deductibles based on household income; no deductible for pre-existing conditions

Table 8: Group and Non-Group Insurance Initiatives in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
ID				
	Idaho Individual High Risk Reinsurance Pool[6] 2000	Residents < 65 who are deemed uninsurable under Medicare or Medicaid, rejected by private individual insurers, offered coverage at a rate higher than the pool rate	1,462 enrollees as of 6/2005	Benefits: Benefits vary by plans; includes • In-patient/out-patient hospital • X-ray • Prescription drug coverage • Preventive care No vision care or dental benefits. Disease management programs may be offered by individual insurers. Lifetime max ranges from $500,000 - $1 million depending on plan. 12-month waiting period for pre-existing condition coverage. Cost Sharing: • Basic plan: $500 deductible, 50/50 coinsurance • Standard plan: $1,000 deductible, 70/30 coinsurance • Catastrophic A: $2,000 deductible, 70/30 coinsurance • Catastrophic B: $5,000 deductible, 80/20 coinsurance • HAS-compatible plan: $3,000 deductible, 60/40 coinsurance • Premium capped at 125%-150% of standard individual risk rate Reinsurance Cost Sharing: Insurer responsible for the first $5,000 in claims; reinsurer responsible for 10% of the next $25,000. For claims exceeding $25,000, the reinsurance pool pays up to the lifetime max of guaranteed issue products.[7]

Table 8: Group and Non-Group Insurance Initiatives in Montana, Idaho, South Dakota, and Utah				
State	**Initiative**	**Eligibility**	**Enrollment**	**Benefits**
SD				
	South Dakota Risk Pool[8] 2003	Residents deemed uninsurable under Medicare or Medicaid, have had at least 12 months of previous continued coverage in the past, and applied for coverage within 63 days of coverage loss Applicants with pre-existing conditions who have been denied private coverage are eligible only if creditable coverage was lost[9]	628 individuals as of 5/2005	Benefits: • In-patient/out-patient hospital • X-ray • Prescription drug coverage • Disease management No preventive care, vision, or dental care services. Lifetime max of $1,000,000 Cost Sharing: • $1,000, $3,000, and $10,000 deductibles • 75/25 coinsurance • Premium rates capped at 150% of standard risk rate
UT				
	Utah Comprehensive Health Insurance Pool (HIPUtah)[10] 1991	Residents who have exhausted COBRA or state continuation coverage, have been rejected by private insurers, but applied for HIPUtah within 30 days following coverage denial	3,085 individuals as of 5/2005	Benefits: • In-patient/out-patient hospital • Prescription coverage • Preventive • Vision. No dental care or non-medically necessary services covered. Lifetime max of $1,000,000. 6-month waiting period for pre-existing condition coverage Cost Sharing: • $500, $1,000, and $2,500 deductibles • 80/20 coinsurance • Premium rates capped at 150% of standard risk rate • Prescription drug deductibles vary across tiers
	Individual Limited-Benefits Plan[11] 2002	Uninsured individuals	As of 7/2004, no carriers have filed	Benefits: Primary and preventive services similar to those under Utah's Primary Care Network (1115 Waiver, see Table 5) Inpatient care and long-term services are not covered.

Table 8 notes:

[1] All information for the MT Comprehensive Health Association comes from Communicating for Agriculture and the Self-Employed, Inc. (2005).
[2] All information for the MCHA Premium Assistance Pilot Project comes from Communicating for Agriculture and the Self-Employed, Inc. (2005), unless otherwise indicated.
[3] MT Department of Public Health and Human Services (2006a).
[4] All information for MT's Individual Limited-Benefits Plan comes from Friedenzohn (2004), unless otherwise indicated.
[5] State Coverage Initiatives (2005b).
[6] All information for ID's Individual High Risk Reinsurance Pool comes from Communicating for Agriculture and the Self-Employed, Inc. (2005), unless otherwise indicated.
[7] State Coverage Initiatives (2005a).
[8] All information for SD's Risk Pool comes from Communicating for Agriculture and the Self-Employed, Inc. (2005), unless otherwise indicated.
[9] State Coverage Initiatives (2006b).
[10] All information for UT's Comprehensive Health Insurance Pool comes from Communicating for Agriculture and the Self-Employed, Inc. (2005).
[11] All information for UT's Individual Limited-Benefits Plan comes from Friedenzohn (2004).

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